Sunny Start
Children's Center

Intake Packet

PERSONAL INFORMATION

Child's Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

Parent/Guardian name – if applicable: _____

Phone Number: _____ LINE ID: _____

Email: _____

Father's occupation: _____ Mother's occupation: _____

Family's monthly average income:

☐ 0 - 30,000 ☐ 30,001 - 80,000 ☐ 80,001 - 150,000 ☐ 150,001 - 300,000

☐ 300,000+

Child lives with (check one)

☐ Birth Parents ☐ Grandparents ☐ One Parent

☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Other _____

What is the child's native language? _____

Are there any other languages spoken at home? ☐ Yes ☐ No

If yes, which one(s)? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

SCHOOL HISTORY

If your child is in school, please answer the following

Name of school and year/grade in school: _____

_____

Teacher's name: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty in any subjects? _____

_____

Is your child receiving help in any subjects? _____

_____

SPEECH-LANGUAGE-HEARING

Do you feel your child has a speech problem? ☐ Yes ☐ No

If yes, please describe. _____

_____

Do you feel your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe. _____

_____

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

What was he/she working on? _____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?

_____

_____

What do you see as your child's most difficult problem in the home?

_____

_____

What do you see as your child's most difficult problem in school?

_____

_____

BIRTH HISTORY

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe. _____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe. _____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If the child stayed at the hospital, please describe why and how long?

_____

MEDICAL HISTORY

Does your child have an underlying disease or had any serious injury/surgery? ☐ Yes ☐ No

If yes, please describe. _____

_____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? _____

_____

Please list any medications your child takes regularly:

_____

_____

ADDITIONAL COMMENTS

Main Area(s) of Concern:

_____

_____

_____

_____

Goals for Therapy (optional):

_____

_____

_____

_____

Other additional information you would like to inform us of (optional):

_____

_____

_____

_____

_____

CONSENT TO SERVICES

1. I would like Sunny Start Co., Ltd. to provide allied health services to my child and/or facilitate parent's workshops, and lessons.

2. PAYMENT

I understand that I must pay for my services prior to scheduled sessions OR as specified on the quotation/invoice.

3. RIGHTS

I understand that:

- I have the right to refuse any services.
- I have the right to discuss all allied health services with my provider.

4. EXCHANGE OF INFORMATION

I understand that:

- Any information exchanged with my provider via email or text will become a permanent part of my service record.
- Any text or email messages sent to Sunny Start Co., Ltd. are not on a secure network. Sunny Start Co., Ltd. cannot be responsible for keeping this information confidential.

RATES

I agree to the service rates informed. Sunny Start Co., Ltd. reserves the right to make adjustments to pricing at any time without further notice. However, services that have been paid prior to adjustment of prices will be honored.

PLEASE PAY TO

Bank: Kasikorn Bank
Name: Sunny Start Co., Ltd. (บจก. ซันนี่ สตาร์ท)
Account Number: 176-3-57899-9

CANCELLATION POLICY

For single, appointment-based sessions, scheduled appointments must be cancelled prior to 6 am of the appointment date. Therapy is neurologically based and relies upon incremental gains and adjustments in order to make and maintain progress. When a client does not show up for a scheduled appointment, the opportunity to continue these gains in lessened. **If a client does not cancel prior to 6 am of the appointment date, the session will be billed automatically.**

If a client misses three scheduled sessions, without advance notice, within a 3-month period of time, it will be at the discretion of the treating therapist as to whether or not they will be able to continue to treat that individual regardless of paid services.

For school-based package sessions, please inform of planned absences during quotation review. Informed absences during quotation review will not be billed. Cancellations during the term will be billed automatically. In the event of therapist cancellation, sessions will be made up.

CONSENT TO SHARE INFORMATION

I, _____ (parent or client), hereby authorize Sunny Start Co., Ltd. to disclose confidential information of _____ (client), including,

- ☐ timetables
- ☐ family profile
- ☐ educational profile and reports
- ☐ chat communications
- ☐ medical servies/records
- ☐ session notes
- ☐ assessment report
- ☐ other

to my child's current school,

OR specify below (case manager, attending doctor, etc.)
_____, and vice versa.

I understand that I may revoke or cancel this consent in writing at any time. The only exception is if this consent was used to communicate information with the above authorized person or agency and that communication is in transit. Otherwise, this consent expires automatically as follows: [Tick your choice]

- ☐ no more than one year from the date of discharge from treatment services
- ☐ on this date: _____

I understand that generally Sunny Start Co., Ltd. may not condition my treatment on whether I sign a consent , but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

PHOTO RELEASE

I, _____ (parent or client), give permission for Sunny Start Co., Ltd. to photograph/videotape me/my child, _____, and use the photo/videos for:

Please specify which of these you will permit (Yes/No)

- ☐ 1. For treatment and evaluation purposes only.
- ☐ 2. To be used with other professionals working with you or your child.
- ☐ 3. To be used for professional meetings/presentations.
- ☐ 4. To be used for presentations to appropriate audiences; stuttering groups, parent groups, undergraduate classes, etc.
- ☐ 5. To be used on social media.

OR

I, _____ DO NOT give permission for Sunny Start Co., Ltd. to photograph/videotape me/my child _____ and use the photos/videos for any purpose.

I understand, accept, and agree to all the terms and conditions stated above.

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

_____

Print Name